

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/21/2016  
FORM APPROVED  
OMB NO. 0988-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445156	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/08/2016
NAME OF PROVIDER OR SUPPLIER  LAUREL MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 902 BUCHANAN RD NEW TAZEWELL, TN 37825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 225 SS=D	<p>During the Recertification survey and investigation of complaints #36977 and #37634 conducted on 6/8/16 through 6/8/16, at Laurel Manor Health Care, no deficiencies were cited in relation to complaint #36977. Deficiencies were cited in relation to complaint #37634 under 42 CFR PART 483, Requirements for Long Term Care Facilities.</p> <p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Robert S. Polchen**Administrator**7/1/2016*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to report and investigate an allegation of abuse for 1 resident (#144) of 4 residents reviewed for abuse of 31 residents sampled.</p> <p>The findings included:</p> <p>Review of facility policy Abuse [and] Resident Rights, (no date) revealed "...Any incident of abuse or grounds for suspicion will result in the following...All reported acts or suspected acts of abuse shall be immediately and thoroughly investigated...a written investigation report shall be completed...examples of abuse...threatening a resident for any reason...the Administrator will investigate any incident as the situation may warrant...will include reporting of results to the proper authorities...Administrator will report all alleged violations...to the state agency...all other agencies as required...take all necessary corrective actions..."</p> <p>Review of facility policy Abuse Policy, dated 3/1/14 revealed "...The Administrator will direct a thorough investigation of each such alleged</p>	F 225			

*Robert Polshen*

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F 225	<p>Continued From page 2</p> <p>violation...Administrator is responsible to report the results of all investigations to the state agencies as required by state and federal law...The results of all investigations must be reported by the Administrator to the appropriate state agency, as required by state law, within five (5) working days of the alleged violation..."</p> <p>Medical record review revealed Resident #144 was admitted to the facility on 4/8/16 with diagnoses including Muscle Weakness, Type 2 Diabetes Mellitus, Atrial Fibrillation, Chronic Kidney Disease, Dementia, Major Depressive Disorder, Pain, Anemia, Hypothyroidism, Hypertension, and Heart Failure.</p> <p>Medical record review of the admission Minimum Data Set (MDS) dated 4/15/16 revealed the resident scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident was independent with daily decision making, required extensive assist of 1 person with toileting, and required extensive 2 person assist with transfer and walking in room.</p> <p>Interview with Resident #144 on 6/7/16 at 7:37 AM, in the resident's room revealed "...[Certified Nursing Assistant (CNA) #2] was verbally abusive...she threatened to take my call light away...my son told the administrator about the incident..."</p> <p>Interview with Resident #144's son on 6/7/16 at 4:03 PM, in the conference room revealed "...dad and I discussed the incident with [CNA #2] and I told the Administrator about the incident 2 weeks ago...nothing has been done about it..."</p> <p>Telephone interview with CNA #2 on 6/8/16 at</p>	F 225	<p>1) No other complaints were made by the resident or the family during the remainder the stay related to care or comments made by the staff. The resident was discharged to home on June 14.</p> <p>2) On June 7, 2016 the administrator directed 3 staff members to interview 22 residents using the QIS questions concerning abuse. (These residents that were considered to be interviewable) There were no reports of alleged abuse among the 22 residents interviewed. The administrator reviewed the centers abuse guidelines on June 7 with the Regional Director of Clinical Operations. All staff members on duty on June 7, 2016 were immediately re-educated on the abuse guidelines. A more extensive education about recognizing and reporting abuse was initiated on June 16 using a PowerPoint presentation. All staff members will be reeducated by June 30. Staff on leave will be educated on the 1st day they returned to work.</p> <p>3) The administrator will report any further allegations of Abuse, Neglect or Exploitation according to the regulations as soon as possible when he is made aware of the allegation.</p> <p>4) Any allegation of Abuse, Neglect or Exploitation will be reported according to the federal/state guidelines and the administrator will be responsible for assuring that a complete and thorough investigation is completed and reported accordingly to appropriate officials within the 5 day time frame. The investigation results and outcome will be included in the centers' monthly QAPI meeting for review by the committee for continued compliance and implementation of other interventions if necessary.</p>	6/30/16.	

*Robert J. Pletcher*

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NAME OF PROVIDER OR SUPPLIER  LAUREL MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 BUCHANAN RD NEW TAZEWELL, TN 37825		
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F 225	Continued From page 3 3:25 PM, revealed CNA #2 denied threatening to take away Resident #144's call light.	F 225			
F 242 SS=D	Interview with the Administrator and Social Services Supervisor on 6/7/16 at 4:50 PM, in the conference room, confirmed the allegation of verbal abuse two weeks prior was not investigated or reported to the State Agency until 6/7/16 (14 days).  483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to honor resident choice to have pajama bottoms put on correctly for 1 resident (#53) of 14 residents reviewed.  The findings included:  Medical record review revealed Resident #53 was admitted to the facility on 8/23/10 and readmitted on 6/27/15 with diagnoses including Schizophrenia, Anxiety Disorder, Major Depressive Disorder, and Cognitive Communication Deficit.  Medical record review of the Minimum Data Set	F 242	1) The Director of Nursing Services met with the CNA staff in the Lighthouse on June 8 to re-educate them on the rights of the family and the resident's to make choices specifically concerning clothing during sleep time and awake time. Resident #53 was specifically observed to have her pajama bottoms in the appropriate position. 2) There is potential for any resident to not be clothed in the manner that they or their family chooses for them. The nursing staff made a tour of the Lighthouse on June 7th to ensure that other residents were not impacted.	6/30/16	

Robert G. Polshen

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F 242	Continued From page 4 Quarterly Review Assessment dated 6/16/16 revealed Resident #53's Brief Interview for Mental Status (a test for cognitive ability) score was 3, indicating the resident was severely cognitively impaired.  Medical record review of the Care Plan Conference Summary dated 7/9/16 revealed "...Care Plan Conference 3:30 PM sister of Resident [responsible party] here...Several concerns is on other sheet...#4. P.J.'S [pajamas] not placing her bottoms on at night..."  Observation of Incontinence care on 6/07/16 at 5:57 AM, in the resident's room, revealed Resident #53's pajama bottoms were pulled down below the resident's knees. Continued observation revealed the resident was trying to pull the pajama bottoms up after the incontinence care was provided.  Interview with Certified Nursing Assistant (CNA) #1 on 6/7/16 at 6:11 AM, on the Light House Hall, revealed "...pants are left below the knees so they won't get wet. Most don't have enough clothes to change them every time they get wet..."  Interview with the Director of Nursing (DON) on 6/8/16 at 10:45 AM, in the DON's office, confirmed the DON was aware of the resident's sister's preference to wear pajama bottoms at night. The DON confirmed the facility failed to honor the resident's right to choose.	F 242	3) All staff working in the Lighthouse and Harbor Side were reeducated on the resident's right to make choices and self-determination during the week of June 6. The residents in the Lighthouse and Harbor Side were monitored each morning for 2 weeks to ensure proper sleeping attire was in place. 4) The monitoring of appropriate sleeping attire will continue 3 times per week for 3 months and then one time per week for an additional 3 months. After that there will be monthly checks to ensure continued compliance. The results of the visual checks will be reviewed during the centers' monthly QAPI meeting for additional interventions, if necessary. The topic of self-determination and the right to make choices will be included in the orientation for all new employees in the future.		
F 279 99-D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's	F 279			

Robert S. Phelan

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NAME OF PROVIDER OR SUPPLIER  LAUREL MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 902 BUCHANAN RD NEW TAZEWELL, TN 37826		
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F 279	<p>Continued From page 5</p> <p>comprehensive plan of care,</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to update a care plan for antidepressant and anti-anxiety medication usage for one resident (#112) of 5 residents reviewed for unnecessary medications of 31 sampled residents.</p> <p>The findings included:</p> <p>Resident #112 was admitted to the facility on 7/29/15 with diagnoses including Muscle Weakness, Alzheimer's Disease, Dementia, Hypertension, and Gastroesophageal Reflux.</p> <p>Medical record review of physician's orders revealed an order dated 7/30/15 for Mirtazapine (antidepressant) 7.5 milligrams (mg) every</p>	F 279	<p>1) The care plan for resident #112 was reviewed and updated to assess the potential for falls resulting from the prescribed medications on June 8<sup>th</sup>.</p> <p>2) There is a potential for other residents to have an increase in risk for falls while taking antidepressants or anti-anxiety medications on June 9<sup>th</sup>. The MDS Coordinators identified all residents taking antipsychotics and evaluated them as fall risk. Care plans were modified appropriately.</p> <p>3) The center's care plan team will review and update as appropriate, document the increased potential for falls in the care plans of residents taking antidepressants or anti-anxiety medications that have been identified as being a risk factor.</p> <p>4) Resident falls are reviewed during Clinical Start Up meeting, risk factors are reviewed as well as interventions to prevent recurrence. All resident falls are also reviewed during the Centers' monthly QAPI meeting and Risk Factors will be reviewed to maintain continued compliance.</p>	6/30/16	

Robert B. Blacher

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F 279	Continued From page 6 evening and an order dated 2/17/16 for Ativan (antianxiety) 0.5 mg twice daily as needed.  Medical record review of the facility's Clinical Health Status Quarterly dated 10/15/15, revealed the resident was at risk for falls.  Medical record review of the care plan updated 4/7/16 revealed the resident was at risk for falls. Continued review revealed the care plan did not address the resident taking antidepressant or antianxiety medication, increasing the resident's risk for falls.  Interview with the Minimum Data Set (MDS) Coordinator on 6/8/16 at 8:30 AM, in the MDS office, confirmed the care plan did not address the antidepressant or antianxiety medication or the medications increasing the resident's risk for falls.	F 279			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a medication error rate of less than 5%, with errors observed in the administration of 2 of 27 medications, resulting in an error rate of 7.40%.  The findings included:	F 332			

*Robert J. Polak*

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F 332	<p>Continued From page 7</p> <p>Medical record review revealed Resident #8 was admitted to the facility on 11/25/15, with diagnoses including Muscle Weakness, Chronic Obstructive Pulmonary Disease, Diabetes, and Essential Hypertension.</p> <p>Observation of a medication pass on 6/7/16 at 7:35 AM, revealed Licensed Practical Nurse (LPN) #2 prepared medication for Resident #8. Observation revealed the medication included Toprolol 25 mg (milligram) and Norvasc 10 mg (generic Amlodipine Besylate) (both medications are antihypertensives). Continued observation revealed the LPN administered the medications without taking the blood pressure.</p> <p>Medical record review of Resident #8's physician recapitulation orders for 6/2016 revealed Metoprolol Tartrate 25 mg (Toprolol) 1 tablet by mouth twice daily; hold for systolic blood pressure less than 110 or heart rate less than 55; Amlodipine Besylate 10 mg (Norvasc), 1 tablet by mouth daily; hold for systolic blood pressure less than 100 or diastolic blood pressure less than 50.</p> <p>Interview with LPN #2 on 6/7/16 at 7:45 AM, in the hallway, revealed the LPN had not taken the resident's blood pressure because the resident had been taking the medication long term. Continued interview revealed, due to the resident taking the medication long term, it was not required to take the blood pressure.</p> <p>Interview with the Director of Nursing on 6/7/16 at 9:40 AM, in the conference room, confirmed the blood pressure was to be taken prior to administering hypertensive medications.</p>			F 332	<p>1) The LPN who was noted to commit the medication error by not monitoring the blood pressure on residents receiving antihypertensive medications was observed during the initial medication pass on the next shift that she worked on June 9<sup>th</sup>.</p> <p>2) Blood pressures were obtained on all residents on blood pressure medication. Nursing administration reviewed the medical records of all residents receiving blood pressure medications to ensure that blood pressures were recorded in the medical record and were within the prescribed parameters prior to medication administration on June 8<sup>th</sup>.</p> <p>3) All LPNs and RNs were reeducated to follow medication administration parameters for all medications, including antihypertensives on June 9<sup>th</sup>.</p> <p>4) RN nursing supervisors will observe a weekly med pass for 3 months and a monthly observation by the consulting pharmacist. A monthly observation will be completed by nursing administration thereafter. Any error noted during observation will be reviewed immediately with the nurse in a 1 on 1 present time education. The results will be reported to the QAPI committee Monthly for 3 months then on a quarterly basis</p>		6/30/16
F 441	463.65 INFECTION CONTROL, PREVENT			F 441			

Robert S. Blachar

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F 441 SS-E	<p>Continued From page 8 SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441			

*Robert S. Blecher*

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F 441	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility procedural guideline review, facility audit tool review, observation, and interview, the facility failed to disinfect hands during medication administration for 1 Resident (#8) of 5 residents observed during medication administration; failed to disinfect hands during incontinence care for 12 residents (#51, #87, #49, #65, #81, #84, #40, #128, #35, #53, #90 and #113) of 12 residents observed for incontinence care; and failed to disinfect hands during meal service for 5 residents of 23 residents observed in the main dining room.</p> <p>The findings included:</p> <p>Review of the facility procedural guideline for "Perineal Care" dated 2014 revealed "...Perform hand hygiene. Apply clean gloves...Dispose of gloves...performs hand hygiene..."</p> <p>Review of Peri Care Audit Tool (no date) revealed "...Staff must gather supplies...wash hands, Apply/puts on gloves...Washes hands before leaving the room..."</p> <p>Review of the facility procedural guideline for "Hand Hygiene" dated 2014 revealed "...Wash hands with either plain soap and water or antibacterial soap and water...Before and after having direct contact with patients...After contact with inanimate objects...medical equipment...After removing gloves..."</p> <p>Review of Hand Hygiene Care Audit (no date) revealed "...Hand washing is done before and after each resident contact...Hand washing is</p>	F 441			

*Robert A. Polcher*

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NAME OF PROVIDER OR SUPPLIER  LAUREL MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 902 BUCHANAN RD NEW TAZEWELL, TN 37825		
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F 441	<p>Continued From page 10</p> <p>done every time you remove gloves...removes gloves and washes hands before leaving a room...Washes hands every time gloves are removed..."</p> <p>Observation of a medication administration on 6/7/16 at 7:20 AM, revealed Licensed Practical Nurse (LPN) #1 had prepared the medication with ungloved hands and placed the medication in a medication cup. Continued observation revealed the LPN handed the medication cup for the resident to swallow the pills. Observation revealed the resident dropped one pill. Observation revealed the LPN picked the medication off the floor with bare hands, placed the pill on the medication cart, had coworker witness the destruction of pill, opened the medication drawer, retrieved another pill to replace dropped pill, returned to the resident and administered the pill. Observation revealed the LPN did not disinfect the hands after picking up the pill from the floor, did not the disinfect hands prior to retrieving additional medication from the cart, did not disinfect the hands prior to administering medication to the resident.</p> <p>Interview with the LPN #1 on 6/7/16, at 7:30 AM, in the hallway, confirmed had not disinfected the hands after picking the pill off the floor and had not disinfected the hands before retrieving the new medication, or had not disinfected the hands prior to administering the medication to the resident.</p> <p>Observation of Certified Nurse Aide (CNA) #1 on the Lighthouse Hallway on 6/7/16 from 6:11 AM through 6:07 AM, revealed the following:</p> <p>Resident #51 (room 114A) at 6:11 AM - Observed</p>	F 441	<p>1) The LPN, CNA and Speech Therapist were reeducated on the facility guidelines for infection control specifically for handwashing during medication administration, peritoneal care and meal service on June 9. Each employee was observed performing a return demonstration by management.</p> <p>2) There is potential for other staff members to not follow the facility guidelines for handwashing. All staff members were reeducated about facility guidelines for infection control specifically for handwashing which began on June 9<sup>th</sup>. All staff that has worked through June 30 has been re-educated. Any staff that has not worked will be reeducated prior to their return to work.</p> <p>3) The nursing home management team will monitor the staff daily for compliance with the infection control guidelines for handwashing for 2 weeks, then weekly for 4 weeks and as needed thereafter. Handwashing technique will be included in the orientation program for new employees which will include a return demonstration.</p> <p>4) The results of the monitoring process will be reported monthly at the QAPI committee meetings for 2 months and then quarterly thereafter to monitor for continued compliance.</p>	6/30/16	

*Robert J. Palcher*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445156	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/08/2016
NAME OF PROVIDER OR SUPPLIER  LAUREL MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 902 BUCHANAN RD NEW TAZEVELL, TN 37825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 11</p> <p>CNA #1 provided incontinence care for resident #51 wearing gloves. Continued observation revealed CNA #1 removed the gloves after providing care, did not wash the hands, and proceeded to another resident's room.</p> <p>Resident #87 (room 113A) at 5:15 AM - Observed CNA #1 donned gloves, changed the resident's brief and sheets, removed the gloves, did not wash the hands, and proceeded to another resident's room.</p> <p>Resident #49 (room 116B) at 5:28 AM - Observed CNA #1 donned gloves, checked the resident for incontinence by touching linens under the resident (resident was dry), removed the gloves, and exited the resident's room without washing the hands.</p> <p>Resident #55 (room 116A) at 5:29 AM - Observed CNA #1 donned gloves, changed the resident's brief, removed the gloves, did not wash the hands after removing the gloves, and proceeded to another resident's room.</p> <p>Resident #81 (room 115A) at 5:29 AM - Observed CNA #1 donned gloves, changed the resident's brief, removed the gloves, did not wash the hands, and proceeded to another resident's room.</p> <p>Resident #84 (room 117A) at 5:31 AM - Observed CNA #1 donned gloves, changed the resident's brief, removed the gloves, did not wash the hands, and proceeded to another resident's room.</p> <p>Resident #40 (room 117B) at 5:36 AM - Observed CNA #1 donned gloves, pulled the residents</p>	F 441			

Robert W. Stetson

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445188	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/08/2016
NAME OF PROVIDER OR SUPPLIER  LAUREL MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 902 BUCHANAN RD NEW TAZEWELL, TN 37825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 12</p> <p>palama bottoms down below the knees, changed the resident's brief and sheets. Continued observation revealed CNA #1 removed the gloves, did not wash the hands, and proceeded to another resident's room.</p> <p>Resident #128 (room 119) at 5:44 AM - Observed CNA #1 donned gloves, checked the resident's brief for incontinence with gloved hands (the resident was dry.) Continued observation revealed CNA #1 removed the gloves, did not wash the hands, and proceeded to another resident's room.</p> <p>Resident #35 (room 110A) at 5:48 AM - Observed CNA #1 donned gloves, changed the resident's brief and sheets, removed the gloves, did not wash the hands, and proceeded to another resident's room.</p> <p>Resident #53 (room 105B) at 5:57 AM - Observed CNA #1 assist CNA #4 with checking the resident for incontinence. CNA #4 instructed CNA #1 to wash her hands before donning the gloves. CNA #4 and CNA #1 donned gloves, and checked the resident for incontinence. CNA #1 removed the gloves, did not wash the hands after providing care, and proceeded to another resident's room.</p> <p>Resident #90 (room 101A) at 5:55 AM - Observed CNA #1 entered the resident's room, and without washing the hands, touched the resident several times during care. Continued observation revealed CNA #1 did not wash the hands after touching the resident.</p> <p>Resident #113 (room 101B) at 6:07 AM - Observed CNA #1 donned gloves, changed the resident's brief, removed the gloves, and did not</p>	F 441			

*Robert J. Blaher*

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445186	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/08/2016
NAME OF PROVIDER OR SUPPLIER  LAUREL MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 902 BUGHANAN RD NEW TAZEWELL, TN 37825		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 13</p> <p>wash the hands before exiting the resident's room.</p> <p>Interview with CNA #1 on 6/7/16 at 8:11 AM, on the Lighthouse Hallway, confirmed she had not washed her hands after removing the gloves.</p> <p>Interview with the Director of Nursing (DON) on 6/8/16 at 10:36 AM, in the DON's office, confirmed the facility's staff was expected to wash their hands before donning gloves and after removing the gloves. Continued interview confirmed the facility had failed to follow their infection control policies for hand hygiene to prevent the spread of infection.</p> <p>Observation of the main dining room meal service on 6/8/16 at 11:45 AM, revealed Speech Therapist #1 moved a male resident in wheel chair closer to table, touched another male resident's ball cap on his head, continuously touched her face and played with her hair, moved female resident in wheel chair to table, retrieved a clean glass from clean cart and gave to another female resident, rubbed her nose and played with her hair, walked to clean cart retrieved clean silverware and gave to a different resident, then exited dining room and went into the Therapy Department all without washing her hands.</p> <p>Interview with Speech Therapist #1 on 6/6/16 at 12:07 PM, outside the main dining room, confirmed she had not sanitized the hands after contact with multiple residents and wheel chairs.</p> <p>Interview with the DON on 6/8/16 at 10:36 AM, in the DON's office, confirmed the Speech Therapist #1 should have washed her hands in between residents during the meal service. Continued</p>	F 441			

*Robert A. Polak*

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/08/2016
NAME OF PROVIDER OR SUPPLIER  LAUREL MANOR HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 802 BUCHANAN RD NEW TAZEWELL, TN 37826		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page 14 Interview confirmed the facility failed to sanitize hands during the meal service.	F 441			

*Robert G. Polcher*